Access Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Access Homecare is a domiciliary care agency. At the time of the inspection, the service was providing personal care to 24 people. This included older, younger adults, people living with dementia and people with a physical or learning disability. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The feedback we received about the service was mixed. People told us about times when calls were missed, staff left calls early and their home had not been left clean and tidy after staff had visited them. However, other people were positive about the service they received. One person said, "There is nothing I think they need to improve on, it's all okay and all works fine."

Whilst there was enough staff to cover care calls, staff were stretched and the office staff were undertaking a considerable number of care calls. This included the acting manager and had an impact on the time they had to improve the service. Staff told us that they did not always have the time they needed between calls and were in a rush to get to the next call at times. Some people told us that they were unhappy about this.

Medicines were not well managed. There was a lack of information about people's medicines such as what they took and what the medicines were for. Medicine records had not been checked to make sure medicines had been given as prescribed.

Risks to people's health and wellbeing had not always been fully assessed. People were at risk of harm because staff did not always have the information they needed to support people safely. There was a lack of personalised information about people's health conditions and how to identify if they were becoming unwell.

Incidents and accidents were recorded. However, these records were not easily identifiable as they were logged on a computer system alongside other communication records. Where incidents had happened, actions had not always been recorded. Incidents had not been analysed for trends and lessons had not always been learned when things went wrong. Systems to check the quality of the service were not robust. Audits were not completed or had not been acted upon and used to improve the quality of care.

The provider had not always treated people with respect as they had failed to maintain the quality of the service. The provider was not able to demonstrate that people were supported to have maximum choice and control of their lives. There was a lack of evidence that staff supported people in the least restrictive way possible and in their best interests. There were no records of decisions being made in people's best interests. There was a lack of information relating to people's capacity to make a decision or that they had given the legal authority for other people to make decisions for them.

Care plans did not always include detailed information about how people wanted to be supported including at the end of their life. There was a lack of information about people's preferences, life history and background. Staff had not considered people's communication needs to ensure that information was provided in an accessible format.

People told us that they knew how to complain if they needed to do so. However, complaints were not recorded in an accessible way. We made a recommendation about this. People did not always feel listened to by the staff and management and their feedback through surveys had not been acted upon.

Staff had not always received appropriate training. Some staff had not completed up to date training on safeguarding and the mental capacity act and were not knowledgeable of confident when talking about these subjects. However, the acting manager and provider had started to address this at the time of the inspection.

Staff had access to the equipment they needed to prevent the spread of infection, such as gloves and aprons. People told us that staff used these when providing care.

People received access to healthcare professionals when they needed this support.

People were receiving adequate support with eating and drinking.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 27/06/2018 and this is the first inspection.

Why we inspected
This was a planned inspection based on the date of registration.

Enforcement:
We have identified breaches of the Regulations in relation to safe care and treatment, the safe recruitment of staff, the management and oversight of the service, personalised care and consent to care and treatment.

We planned to take action against the provider to impose conditions on the service. However, the provider took the decision to close the service and the service is no longer registered with CQC..

Follow up
We met with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. The provider took the decision to close the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Access Homecare Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission. This means that the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. However, we did not receive any responses. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We also visited

two people in their own home. We spoke with the acting manager and five other members of staff. The provider was not available to speak to at the time of the inspection.

We reviewed a range of records. This included six people's care records and one person's medication record. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification to validate evidence found. We looked at training data and communication records. The provider was out of the country at the time of the inspection. However, after the inspection we spoke with them on the telephone.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicine's management was not always safe. The provider could not demonstrate that people were given their medicines as prescribed.
- Medicine administration records (MARS) were not always returned to the office when they were completed. This meant that some of the records we requested to review were not available and the provider had not checked that staff were completing records accurately. There were gaps in the medicine administration records which had not been accounted for. There was no code list on the MARs sheet for staff to use to indicate why medicines were not given, such as when they were declined.
- Some MARs were hand written and had not been double signed. This is where hand written MARs are signed by two members of staff who have checked that they are accurate.
- There was a lack of information about people's medicines such as what they were for. Staff relied on the information provided by the pharmacy, however office staff did not have this information. This meant that the staff in the office did not have oversight of people's medicines to make the changes they needed to on people's MARs. For example, one person's medicine times had been changed by the pharmacy. Staff in the office were not aware of this and the MARs had not been updated. This meant that the person was at risk of receiving their medicine at the wrong time. We spoke with the acting manager about this who addressed this concern during the inspection.
- Some people took medicine only when required (PRN) such as paracetamol. There were no protocols in place to provide staff with information about this medicine. For example, when it was to be offered and how often it could be taken.
- There were no body maps for tell staff where to apply people's creams. This meant that staff may not have administered the medicines when people needed them or in a consistent way.

We did not identify anyone who had come to any to harm. However, the provider had failed to ensure that medicines were managed safely. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not always assessed, managed or monitored safely.
- The acting manager was in the process of updating care plans and adding risk assessments where these were needed. However, they had not yet completed this task and none of the care plans we looked included sufficient information on all of the risks to people. This meant that staff did not always have the information they needed to keep people safe. For example, one person's assessment stated they were prone to pressure sores. However, the risk assessment lacked detailed information and just stated 'check integrity of skin'. Another person was diabetic, although staff did not provide support with meals. There was no information on how to identify if they were becoming unwell and needed treatment.

● Whilst most staff were aware of the risks to people and had provided appropriate support, there were areas where they did not. For example, one person was on medicine for epilepsy and some staff did not know when the last seizure was and what the person's seizures looked like. Staff had not completed training in epilepsy awareness. This meant that there was a risk that staff would not recognise that the person was having a seizure or know how to support them to remain safe.
● Where staff used equipment to support people such as hoists and stairlifts they had not always checked to ensure that the equipment was safe. The service had checked that hoists were safe to use but had not checked one person's stairlift.

We did not identify anyone who had come to any harm. However, the provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Lessons had not been learnt when things went wrong, and accidents and incidents were not always managed safely.
● Incidents and accidents were recorded on the service's IT system. Incidents were not categorised which meant they were not easy to identify. There was no system to monitor if incidents had been dealt with. This meant that the acting manager had no ability to monitor incidents to ensure that they were actioned appropriately and protect people from the risk of re-occurrence. There was no analysis of accidents and incidents to check for trends. At the time of the inspection, the acting manager was in the process of improving the system of recording incidents and accidents. However, this system had not yet been fully implemented.
● The service was not able to demonstrate that incidents had been actioned appropriately. For example, in May 2019 staff reported a concern that one person's medicine did not match the count on the medicine record. There was no evidence that this concern had been investigated or acted upon.

We did not identify anyone who came to harm. However, the provider had failed to ensure that incidents and accidents were appropriately recorded, investigated and acted upon. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider was not able to demonstrate that staff had been recruited safely. The provider's policy was that staff needed two references, one of which must be the last employer. Two staff members files did not contain references from their last employer. This meant that the provider had not followed the services recruitment procedures. One missing reference was for work carried out in a social care setting. The meant that the provider failed to ensure that there was satisfactory evidence of conduct in previous social care employment.

The provider had not completed the appropriate checks to ensure that staff were recruited safely in to the service. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other pre-employment checks had been undertaken. For example, Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.

● Office staff including the acting manager regularly undertook care calls to make sure that calls were

covered. The acting manager agreed that this was not sustainable in the long term and that they needed more staff to continue with the calls they were currently doing. The service was relying on staff working more hours to cover absences and sickness. One staff told us, "With staffing issues it's turned from a little job to a big job."

● The provider was away at the time of the inspection but responded immediately afterwards. They were able evidence that they had reduced the number of people the service supports to address the concerns about the acting manager undertaking care calls.

● Staff told us that there was sometimes a lack of travel time for between calls. One staff told us, "Sometimes they don't give me the travel time I need between calls. Sometimes the distance is really long. I try and do some calls early." One person said, "They stay the full length of time but then I wouldn't let them go anyway." However, we found evidence that there had been times when staff had not stayed the full length of the call. For example, one person was due to have a 45-minute call from 10am. Staff arrived at 10.08am and left at 10.30am. We spoke with the person who told us that they were not happy when staff rushed off.

The provider had failed to ensure that there was sufficient staff to provide support to people. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the provider after the inspection who agreed that the service needed to improve. In response to our concerns they reduced the number of people supported by the service to reduce the number of care calls staff needed to complete.

Systems and processes to safeguard people from the risk of abuse

● The provider had failed to ensure staff understood their roles and responsibilities to safeguard people from the risk of abuse. Some staff had not updated their safeguarding adults training. The staff we spoke with were not always confident or knowledgeable about abuse. For example, staff did not always understand the different types of abuse such as neglect. Neglect is where a person deliberately withholds, or fails to provide, suitable and adequate care.

● Staff were confident that the acting manager would act upon concerns. However, if they did not act on the concern staff did not always know who to contact outside of the service. One staff said, "I don't really know who to go to about it."

● The acting manager had identified this concern prior to the inspection and staff training was being updated at the time of the inspection.

Preventing and controlling infection

● Staff had access to appropriate equipment such as gloves to use the prevent the risk of spreading and infection. We observed that staff used these.

● However, not all staff had undertaken training in infection control and food hygiene to enable them to support people safely. There were no records of spot checks where the acting manager had checked that staff were following safe practice. This was an area for improvement.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty. We checked whether the service was working within the principles of the MCA

● The service was not able to demonstrate that they were following the principles of the MCA. The acting manager told us that one person had a Power of Attorney (POA) in place. A power of attorney is a legal document that gives a named person authority to make decisions on a person's behalf. There was no copy of the POA available at the inspection to demonstrate that this was in place. During the inspection, we identified one other person whose capacity fluctuated due to a medical condition and two people who had variable capacity. There were no best interest records for any people using the service and no records of capacity assessments for any decision.

The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed that people were offered day to day choices such as what they wanted to eat. Staff supported people who found it difficult to make decisions by offering them choices and using items of reference. For example, one person was supported to go shopping and staff used objects of reference from their cupboards and in the shops to help people decide what they wanted.

Staff support: induction, training, skills and experience
● Staff did not always have the training they needed to deliver safe and effective care. For example, some staff had not completed up to date training in safeguarding, health and safety, the mental capacity act and medicines administration. Staff had not undertaken training in supporting people with a learning disability. This is an area for improvement.
● People told us that the staff had the skills they needed. One person said, "I think the staff know what they are doing, I think they are well trained and yes I feel safe with the staff helping me." However, the staff and

the acting manager were unhappy with the quality of training at the service. Training was delivered by staff watching DVD's and completing questionnaires. One staff said, "The training is rubbish."

● Prior to the inspection, the provider and acting manager had put plans in place to address this. The acting manager told us they were "starting staff training from scratch" to re-train staff in all areas. The provider told us they supported the acting managers plan to re-train staff. Ten staff had already completed new face to face manual handling training, four staff had started their NVQ in health and social care. During the inspection, five staff started the care certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff in their role. We spoke with one member of staff after they had started this new training, they told us, "We have already started to do our new training. I've done the mental capacity act, medication and safeguarding. I really enjoyed it, it was much more informative."

● Staff completed an induction prior to commencing in the role which included a period of shadowing more experienced staff. Staff supervision meetings had not all been completed. However, the acting manager was in the process undertaking these. Staff had completed an annual appraisal to discuss their performance and any concerns they may have.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Prior to starting the service people's needs were assessed. This assessment included information on people's needs such as communication, nutrition and hydration, personal care, health concerns and cultural and religious needs. However, these assessments had not always been used to develop a care plan. For example, one person's assessment identified that they had diabetes and epilepsy and there were no risk assessments to provide details about these ailments. This meant that staff may not know what to do if the person became unwell.

● Care was not being delivered in line with standard, guidance and the law. For example, medicine administration and recording were not completed in line with current guidance.

Supporting people to eat and drink enough to maintain a balanced diet

● Not everyone using the service needed support with eating and drinking.

● We observed staff offered people choices of food and drink and ensured that these were in reach.

● Some people were supported to go shopping and choose their own meals. There was information on what people could make for themselves and what they needed support with. For example, if people could make hot drinks safely alone.

● People were happy with the support they received with eating and drinking. One person said, "One does my shopping and gets me what I want and then they make the meals. I am quite happy with it. They offer me a drink, I mostly drink water and they make sure that the bottles of water are in reach when they go."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● If people needed to go to hospital there was a lack of information for them to take with them. For example, people with learning disabilities did not have hospital passports in place. These are documents which provide healthcare staff with information on the person's care needs and medicines. This is an area for improvement. However, one person needed to go to hospital during the inspection and staff had accompanied them and stayed with them.

● Where people needed support to access healthcare appointments this was in place.

● Staff had identified where people were unwell and had taken action to support them to access healthcare. One person said, "One day, one of the carers came and said that she didn't like the look of me. She called the GP, but they couldn't come out, so they called the ambulance who came and I went in to hospital. I was in for a week and then needed 2 weeks in rehab, so I must have been unwell."

● Where people needed a referral to a health care professional such as an occupational therapist or GP the service had provided this support. For example, one person had been referred to an occupational therapist due to changes to their mobility and the service was arranging to support the person to receive some new equipment as a result.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● People were not always treated with respect by the provider as systems to keep people safe from harm and protect them from risk were not always in place. For example, there was a lack of risk assessments and staff did not always have the training they needed to support people with their health conditions.
● Staff supported people to maintain their dignity. Staff told us that they shut doors and helped people to remain as covered up as possible while providing personal care. One person said, "They stay outside while I do the bits I can do and then I call them in and they help me to finish."
● People were positive about staff supporting them to be independent. "If I have a bad day, they encourage me to get up and get going. If I need them on days where I am a bit slow, they hang about and help me." And, "When they first came I made it really clear that I did not want them to take away my independence away. They told me that they would not do that. I am getting better now and I can do somethings for myself more."
● People's records were kept private. Care plans were kept in locked cabinets in the office and people had copies in their own home.

Ensuring people are well treated and supported; respecting equality and diversity
● People using the service were not always well treated and supported. For example, staff had not always stayed the full length of the call when they should have.
● People's feedback about care staff was mixed. Comments from people included "There is one carer I have who doesn't stay as long as they should, they don't stay and chat but just rush off as soon as the tasks are done. The girls who I really like, chat to me.", "We have a good laugh and chat." And, "I think they have a good crew and are lucky to have good staff. I think the best thing is that they are trustworthy and that is important."
● Where people had needs relating to their protected characteristics under the Equalities Act 2010 such as needs relating to sexual identity and religious needs, staff provided this support. For example, one person was regularly supported to attend religious services.

Supporting people to express their views and be involved in making decisions about their care
● People had not always been involved in decisions about their care. However, the acting manager was in the process of addressing this concern and working with people and their relatives to update their care plans. One person said, "When the new manager started she came out and sorted the care plan out with me. I'm in control of my care."
● Staff had not always had the time to listen to people. Staff said, "There are some clients where I am really careful to stay sit and chat but other times we are so pushed and stretched for time. Sometimes the service users are happy for us to go, other times I worry about getting to the next call. It would be nice to be able to

have time to stay and talk."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans did not always include personal information. For example, some care plans did not include information on the person's life history, career and family. There was inconsistent information about people's preferences. This meant that new staff would know very little about the person that they were supporting. Staff relied upon people telling them how they wanted to be supported. People said, "I tell them what I want, and they do it." The acting manager was in the process of updating people's care plans to address this.

● There was a lack of information about people's health needs in care plans. For example, one person had a condition affecting their blood vessels. There was limited information about these conditions to enable staff to identify concerns. At the time of the inspection, the acting manager was in the process of updating people's care plans to address this.

People's records lacked personalised information and people were at risk of not receiving personalised care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people needed support to access activities and social events this was provided. For example, one person was regularly supported to go to a day centre and out with friends. They had also been supported to go on holiday and to access special events when they wanted to do so.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider had not acted make sure that it was providing information in a suitable form and the acting manager was not aware of the AIS at the time of the inspection.

The provider had not ensured that people were provided with accessible to enable them to be involved in decisions about their care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● The service was not providing end of life care at the time of our inspection.

● However, some people had conditions that could result in them needing end of life care. Other people had

no family to provide support when they neared the end of their life. People's end of life wishes had not been discussed and there were no plans in place should people need this support.

People's records lacked personalised information and people were at risk of not receiving personalised care at the end of their life. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- There was no complaints log at the service. Any complaints were recorded on the computer system along side other communication records and we were not able to identify any recorded complaints during the inspection.
- People told us that they had not complained or when they had done it was dealt with appropriately. One person said, "All in all I am happy with the service. I have no complaints and there is nothing I would want to change about it." Another person told us, "They did respond to my complaint and dealt with it quickly, I don't have any other complaints."

We recommend the provider establishes and operates an effective and accessible system for identifying, receiving, recording, handling and responding to complaints.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of learning at the service, which meant that care was not being improved in response to learning. Quality audits had not always been effectively completed to monitor and assess the service. Staff completed daily notes to record the events during the care they provided. Some daily notes had not been returned to the service for auditing. Some daily notes that had been returned had been audited but no action was taken following the audits. These audits had not identified important concerns such as staff leaving calls early. Medicine administration records were not always returned to the service and when they were, they had not always been checked for gaps and errors. Audits had also not identified the lack of risk assessments in care plans and the other concerns we identified during this inspection.
- The acting manager did not have oversight of incidents that had occurred and could not analyse these for trends. Incidents had been recorded on the computer system and there was no way to quickly identify these or track that they had been actioned.
- There was no monitoring of staff timekeeping or concerns over call length. This meant that the provider had not identified concerns and addressed these. During the inspection, we identified calls that had been missed and calls where care staff had left early. However, we did not identify, and harm had come to people as a result.

The provider failed monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There had been not been an open culture at the service and the service had not had stable management. One person said, "What worries me is that the manager had changed a number of times in the last year. This does worry me, they don't always let me know. You only find out if one of the carers says something."
- People's records were not complete. Some risk assessments had not been undertaken and there was a lack of information about people's life history or preferences. The acting manager was updating care plans and told us "The care plans had not been updated regularly. I've stated doing reviews to get them up to date, but I am nowhere near finished." Medicine administration records had not always been completed.
- There was a lack of oversight on staff performance. Spot checks and competency assessments had not been completed to ensure that staff were undertaking tasks such as manual handling and medicine administration safely.
- The acting manager had only recently started at the service and since then had spent a considerable

amount of time providing care for people. This meant that they did not have the time they needed to make more improvements to the service.

The provider had failed to ensure that people's care records were complete. Systems and processes to improve care were not always in place. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the provider after the inspection who agreed that the service needed to improve. In response to our concerns they reduced the number of people supported by the service to make sure that the acting manager had more time to focus on improvements. The provider then wrote to inform us that a new manager would be starting at the service on 4 July 2019.

● People and staff were positive about the acting manager and told us that they were making improvements. One person said, "It all went a bit wrong under the old manager, there were issues with staff leaving and I was getting lots of different people come and see me, but I wasn't going to put up with it. The acting manager has sorted all this out and things have settled down now." Staff said, "I no longer want to leave as things are on the up." And, "The manager is really supportive, she is always there for you."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There had been no meetings for care staff since March 2019 and the records from this meeting were limited. However, staff said that communication was improving at the service. One staff said, "The last time we had a staff meeting it wasn't very good and I didn't enjoy it. Communication is a lot better than what it was."

● A survey had been undertaken for people to feed back on their concerns in 2018 prior to the acting manager starting at the service. Whilst most of the feedback was positive there were seven questions were one or two people had answered 'poor' and nine questions where one or more people had answered 'satisfactory' rather than 'good' or 'very good'. For example, two people had rated the service as 'poor' for help given regarding taking medicine. There was no action plan or information on what had been done to improve the areas where people had raised concerns. One person said, "They do send a survey, I have mentioned things and things haven't changed. The manager changes so often so it's difficult to get them to do something about things. You don't know who to speak to and if you raise things they leave so things don't get done."

● There had been no survey for professionals to gather their views. The acting manager told us that there had been a survey for staff, however, no one had access to the results and there was no information or action plan relating to anything staff may have raised.

The provider had failed to seek and act on feedback from people and those involved in their care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was no registered manager at the service. The registered manager left in May 2019 and at the time of the inspection and no application had been submitted for a new registered manager. CQC had not been informed in a timely manner that managers had left the service. We spoke with the provider about this who told us that this was due to them being out of the country.

● The provider was aware of their responsibilities about reporting significant events to CQC.

Working in partnership with others

● The acting manager had not yet attended events or networks to under any learning or develop partnerships with others. This is an area for improvement.

● The service was working in partnership with some health and care professionals. For example, one person needed support from the occupational therapist and staff were supporting the person to accept the recommendations made by this professional so that they could remain safe in their own home.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's records lacked personalised information and people were at risk of not receiving personalised care including at the end of their life. The provider had not ensured that people were provided with accessible to enable them to be involved in decisions about their care.

The enforcement action we took:

We planned action against the provider. However, the provider took the decision to close the service.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that the principles of the Mental Capacity Act 2005 had been complied with.

The enforcement action we took:

We planned action against the provider. However, the provider took the decision to close the service.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were managed safely. The provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety. The provider had failed to ensure that incidents and accidents were appropriately recorded, investigated and acted upon.

The enforcement action we took:

We planned action against the provider. However, the provider took the decision to close the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good

	governance The provider failed monitor and improve the quality and safety of the services provided. The provider had failed to ensure that people's care records were complete. Systems and processes to improve care were not always in place. The provider had failed to seek and act on feedback from people and those involved in their care.

The enforcement action we took:

We planned action against the provider. However, the provider took the decision to close the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not completed the appropriate checks to ensure that staff were recruited safely in to the service.

The enforcement action we took:

We planned action against the provider. However, the provider took the decision to close the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that there was sufficient staff to provide support to people.

The enforcement action we took:

We planned action against the provider. However, the provider took the decision to close the service.